

Appendices

Appendix A. Data Assessment

Appendix B. TREbase Data on Values of Selected Plan Design Elements—By Plan Type

Appendix C. Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans 2000

Appendix D. RWJ Foundation Employer Health Insurance Survey

Appendix E. Washington State Planning Grant on Access to Health Insurance Private Payer Questionnaire

Appendix F. Summary of Responses to Private Payer Questionnaire and a “Combined” Response

Appendix G. Washington State Mandated Benefits

Appendix A

Data Assessment

National Survey Data

To assess the extent and variation among employer-sponsored medical plans, Mercer Human Resource Consulting (Mercer), and the RAND Corporation (RAND) abstracted data from three existing national data sets in our possession, all of which have a Washington State subset. The sources of national survey data for this analysis are described in the table below.

Data Source (and Timing)	Survey Design	Washington-Specific Data?	Sampling Approach
Benefits Valuation Survey – TREbase (ongoing survey of Mercer Human Resource Consulting)	Written questionnaire supplemented by information abstracted from in-force summary plan descriptions (SPDs) and other documents	National with Washington subset	Public, private for-profit and private not-for-profit employers ranging in size from small start-up companies to large Fortune 500 companies
2000 Mercer/Foster Higgins Survey of Employer-Sponsored Health Plans	Written questionnaire	National with Washington subset	Representative of all employers with 10 or more employees
1997 Robert Wood Johnson Foundation (RWJF) Employer Health Insurance Survey	Written questionnaire	National with Washington subset	National probability sample of private and public employers, with a specific emphasis on the 60 communities of the <i>Community Tracking Survey</i> and 12 states with substantial rating reforms in the small group market.

Based on our review of these data sets, we cannot confirm the prevalence of certain plan design features on a basis that is representative of the entire covered population in Washington. Data limitations and available information obtained from these sources are described in the following pages. We have focused our attention on deductibles, general coinsurance levels, selected copayments, prescription drug cost sharing, and out-of-pocket maximums, because they are more likely to be found in the surveys.

TREbase

Mercer annually conducts a Benefits Valuation Survey (BVS), whose resulting data are entered into a proprietary database called TREbase. The survey and database cover the range of employee non-cash benefits, including medical and dental plans, leave policies, pension plans, employee stock ownership plans, life insurance plans, short- and long-term disability plans, profit-sharing plans, and sick leave plans, among others. In addition to current Mercer clients, Mercer sends out marketing materials to organizations on the lists of Fortune 500 companies, Best 100 companies, Best 100 hospitals, and trade associations to gauge interest in the BVS. The BVS is also accessible through the Internet. Participants in the survey include public, private for-profit, and private not-for-profit employers ranging in size from small start-up companies to large Fortune 500 companies.

The survey seeks detailed data on various benefit packages, contribution requirements, COBRA rates, discretionary employer contributions, and executive benefits among organizations with varying characteristics (workforce size, sales, type of industry, region, specially designated peer groups). Data from each respondent's completed survey instrument (questionnaire) and SPD(s) are abstracted and captured in TREbase for purposes of sorting and reporting. TREbase can then be used to generate benchmark data, comparative data, and prevalence data across groups of employers, as well as total compensation valuations for one or more organizations. Certain identifiable data are maintained as confidential; other data can be masked or aggregated in the reports.

The TREbase data set contains more than 300 variables in order to capture the widest range of detail. To maintain the usefulness of these data to the state, and to make it manageable, Mercer sorted the data in fall 2001 along a number of dimensions.

We only explored the medical benefit packages reported in place on or after January 1, 2000. Experience indicates that benefit packages often change every few years, and the types of medical cost increases seen in the last year or two are more likely to have generated change than the more moderate increases seen in earlier years.

Medical package data in the data set are captured along four dimensions—cost sharing, cost management, plan features, and prescription drugs. We have attempted to address only those dimensions that address plan benefits per se, rather than eligibility rules, contributions toward coverage, COBRA rates, or retiree coverage issues. For example, we did not review data on eligibility rules (e.g., the limiting age for dependent children), contribution amounts or percentages, waiting periods before coverage takes effect, special out of area benefits, basic vision benefits, retiree coverage or the presence/absence of a “silent PPO.”*

We also disregarded selected details on in-network versus out-of-network benefits, such as whether every type of incurred and covered charge applies to a deductible.

We have focused on only the most important elements of prescription drug coverage and cost sharing. Accordingly, we are not evaluating prescription drug network arrangements or freestanding programs.

We determined that of the approximately 1,000 employers in the data set from around the United States, 734 employers with 12,000,000 employees and 2,258 medical plans had medical benefit data current as of January 1, 2000, or after. Similarly, of the 23 participating employers in Washington, 18 employers with more than 270,000 employees and 55 medical plans had medical benefit data current as of January 1, 2000, or after. We have since obtained newer medical plan data covering 874 employers with 2,701 medical plans from around the United States. For Washington, 20 employers with 62 medical plans and 295,000 covered employees now participate in the survey. Among the participating Washington employers are public and private organizations ranging from a few hundred employees to those with approximately 100,000 employees. The number of medical plans offered by each of these employers is fewer than ten and in most cases fewer than five (all except one offer more than one plan).

*A silent PPO allows plan participants and sponsors to obtain the financial advantages of PPO discounts simply by “accidentally” using network providers, without having plan design incentives to use them.

The major package design elements, and the primary values observed for them, are shown in Appendix B for the U.S. and Washington by plan type (PPO, HMO, etc.). For Washington plans, the number of applicable *plans* is too small to calculate a reliable statistic on a particular feature (e.g., individual deductible); in those cases, we provide plan counts instead of percentages. Additionally, we are unable to calculate the percentage of *persons* covered by various plan design features, as plan sponsorship (and enrollment counts) of the plans have been masked due to confidentiality requirements. Finally, we have not provided all the back-up tables associated with this analysis.

The Washington plans are primarily managed care plans (79 percent). Twenty-nine percent are HMOs, 35 percent are PPOs, and 15 percent are POS plans. Accordingly, most have no individual deductible for in-network services and their non-network, individual deductibles range from \$100 to \$500 per year, but cluster between \$200 and \$300. Most plans do not require a family deductible for in-network services and have out-of-network family deductibles ranging from \$300 to \$1,500. For the traditional indemnity plans still remaining, the most common individual deductible was \$100, and the most common family deductible was \$300. Higher deductibles were most common for out-of-network benefits in the managed care plans.

Nationally, plans using deductibles cluster at \$200 and \$250 per individual and at \$200, \$250, \$300, and \$500 per family. Indemnity plans with a coinsurance arrangement still appear to use 80 percent/20 percent designs (as indicated by hospital coinsurance amounts). Managed care plans used lower coinsurance amounts for in-network services and 20 percent or 30 percent for out-of-network services. For managed care plans using copayment arrangements, the most common copayment is \$50 for emergency room visits, \$10 for office visits (\$15 in indemnity plans), and \$100 for inpatient hospital admissions (\$150 in indemnity plans).

The most frequent annual, individual out-of-pocket limits nationally range from up to \$1,500 in-network and up to \$3,000 out-of-network (\$1,000 to \$3,000 in Washington). When separated by plan type, it appears that most plans focus on individual out-of-pocket limits only, if any.

The prescription drug benefit data captured in TREbase needs to be considered carefully. Superficially, if reviewing coinsurance requirements, it would appear that many plans cover prescription drugs in full (at 100 percent). We believe the correct interpretation would be that prescription drugs are generally covered in full after applicable copayments. Frequent copayments for brand name drugs in Washington appear to be \$10 (generally for 30 or 34-day supplies), while generic drug copayments are more likely to be \$5. Brand name copayments are frequently higher in the rest of the U.S.

The primary lifetime benefit maximum in Washington plans appears to be \$1,000,000, although some plans here and throughout the country have adopted an unlimited benefit maximum.

Mercer/Foster Higgins Survey of Employer-Sponsored Health Plans

The Mercer/Foster Higgins National Survey of Employer-sponsored Health Plans is another Mercer data set, capturing information on a wide range of issues concerning employer health plans, including costs, strategic planning, plan provisions, and scope and limitations of coverage. To obtain information on private employers, Mercer used a Dun & Bradstreet database to draw a sample stratified in eight size categories. Only one response per employer was accepted, even if an employer had multiple work-sites or establishments. For government agencies, the Census of Governments was used to develop random samples of state, county, and local governments.

Questionnaires were mailed to large employers in the sample in June 2000. An Internet-based version of the survey was made available to large employers as well. Telephone follow-up for the random sample began in August of that year. Employers with fewer than 500 employees were contacted only by telephone, because they have historically exhibited low response rates to the mailed questionnaire. Slightly more than half the respondents gave telephone interviews, and some mail respondents were contacted by phone to clear up inconsistent or incomplete data.

The resulting database contains data from 3,326 employers who sponsor health plans. Results can be examined separately for employers with 500 or more employees (“large employers”) and “small employers” with up to 499 employees, as well as both together. The larger size groups were over-sampled, but their responses were then weighted to reflect the proportions of such firms nationally. The weighting scheme was also designed to provide information representative of all employer health plan sponsors with 10 or more employees nationally, as well as for four geographic regions of the country.

Only a limited amount of data in the survey addresses plan design and cost sharing at time of service. Instead, the survey provides a more comprehensive view of:

- Plan type
- Eligibility/enrollment
- Overall health plan costs
- Contribution strategies
- Employers’ health care costs as a percent of payroll
- Criteria for selecting/managing health care plans
- Methods of assessing the quality of medical care
- Use of electronic media for plan administration
- Planned changes

Further, data on Washington from this study may not be representative of the state’s employer-sponsored plans, because of insufficient numbers and weighting that were not geared to permit a representative state-specific analysis.

The available data on plan type and plan design (see Appendix C) indicate that larger Washington employers (500 or more employees) are most likely to offer PPO plans, with HMO plans and point-of-services (POS) plans considerably less common. Only one-quarter of larger employers in this state offer traditional indemnity plans. The primary deductible noted is \$200 per individual per year, with office copayments ranging near \$10. The survey does not summarize information on “small employers” in Washington.

1997 Robert Wood Johnson Foundation (RWJF) Employer Health Insurance Survey

The RWJF Employer Health Interview Survey provides limited data on plan design. Instead, its broader objectives are “to determine what types of businesses offer health insurance to their workers, to estimate the cost of providing employer-sponsored health benefits, and to evaluate programs and laws aimed at controlling health insurance costs.” The Research Triangle Institute in North Carolina conducted the survey, with guidance from both RWJF and RAND, using “a national probability sample of private and public employers, with a specific emphasis” on 60 communities and 12 states, including Washington. The sample of private employers was again drawn from a Dun & Bradstreet database, and the public employers were drawn from the 1987 and 1992 Census of Governments, although we have focused here on the private employers only.

Issues covered by the survey included:

- Waiting periods
- Minimum hours of employment per week to be eligible for coverage
- Availability of retiree coverage
- How coverage was secured (e.g., through a purchasing cooperative, broker/agent)
- Plan types that were available to the employer, and their costs
- Number and types of plans in place and associated premiums
- Whether the plan(s) is(are) insured or self-insured
- Employer contribution strategy
- Coverage tier structure
- Underwriting rules
- Presence of carve-out plans
- Characteristics of employers (workforce size, industry, financial ratings, public or private, employee earnings, salaried or hourly workforce)

The data were captured and available on small Washington groups (with fewer than 50 employees) and larger groups, whether insured or self-insured. The private employer data drawn from this survey permitted a limited analysis of deductibles, in- and out-of network cost sharing, out-of-pocket maximums, and prescription drug cost sharing. (See Appendix D.)

The design of this survey permits a more precise estimate of the prevalence of selected plan features and levels than do the other national surveys, allowing the calculation of the percentage of enrollees in employer-sponsored plans with specified benefits. However, the data are at least five years old and current values might look considerably different given employers' recent responses to the newest surge of health care cost inflation.

The top three deductibles in all employer-sponsored plans ranged from 0 to \$250. However, it appears that the variability in deductibles was much more limited for large groups; more than 90 percent of large group enrollees had 0, \$100, or \$200 annual individual deductibles; only three-quarters of those in small groups had deductibles of 0, \$200, or \$250. Interestingly, more than 40 percent of enrollees within each size group had first dollar coverage (no deductible) at the time, presumably due to membership in HMOs or point-of-service plans.

The data set indicated that approximately three-quarters of enrollees in small groups and large insured groups had in-network coinsurance (or no coinsurance) requirements, and one quarter was subject to in-network copayments. In-network benefits would apply to all types of medical plans. For enrollees in large, self-insured plans, somewhat lower percentages of enrollees were involved in coinsurance plans (59.3 percent), and higher percentages of enrollees paid copayments at time of service (40.7 percent). Typical coinsurance levels were 30 percent or less. Approximately one-quarter of all Washington group plan enrollees have a 20 percent cost share, and one in ten had a 30 percent cost share. Almost one in five (19.4 percent) had \$10 copayment arrangements, and just over 11 percent paid \$5 copayments.

Almost three-quarters of group plans in both size and funding categories limited participants' exposure to catastrophic bills. The highest out-of-pocket (OOP) limit at the time was \$2,000. The largest cluster, some 22 percent of all group plan enrollees, had OOP limits set at \$1,000.

Out-of-network cost-sharing arrangements would largely apply to HMOs, PPOs, and point-of-service plans, but not to traditional indemnity plans. These benefits require more participant cost sharing for services of non-preferred or non-network providers of care. Just more than half of small-group plan participants were in PPO or point-of-service plans (53.4 percent); only one-third of large

insured group plan participants (32.4 percent), and almost two-thirds (63.4 percent) of large, self-insured plan participants were covered by similar arrangements. Fewer than half of group PPO/POS plan members had coinsurance requirements for out-of-network services; more than half were required to pay copayments instead. Of those with coinsurance responsibilities for out-of-network care, most paid either 20 percent or 30 percent of allowed charges. For those enrollees with the more common copayment arrangements, about twice as many enrollees paid \$10 copays than the next most common copayment, \$15.

Prescription drug cost sharing was closely divided overall between coinsurance and copayment arrangements. Copayments were more likely to be used in the large group plans with more than 50 employees and did not appear to be set separately for generic medications versus the typically more expensive brand name medications. Twenty percent (20 percent) was the most typical coinsurance level, and the most common drug copayment level was \$10.

It is clear that certain levels of cost sharing were in widespread use in employer-sponsored health plans. However, given the age of the RWJF data, it would not be appropriate to assume the levels of cost sharing seen in 1997 translate readily into today's marketplace.

Survey of Local Private Payers and Products

To augment the existing data sets, the consultant team initially proposed to approach the top ten payers in the state and obtain plan design outlines, enrollment data, and related information on each of their top three products, as well as three "outlier" products. Washington State Planning Grant on Access to Health Insurance staff suggested a modification of the approach in which payers would be asked to provide representative samples of their plans, and distribution data and other such information on all their plans. Difficulties were recognized with regard to obtaining a comprehensive picture of available products (due to the amount of data involved on potentially thousands or tens of thousands of plans), as well as "representative samples." An alternate approach, which would have involved collecting data on plans filed with the Office of the Insurance Commissioner, also proved not to be feasible.

Accordingly, Mercer developed and issued a questionnaire on plan design elements to 10 top payers in the state, including Regence Blue Shield, CIGNA, Aetna, Group Health Cooperative of Puget Sound, PacifiCare, Northwest Administrators, Community Health Plan, Zenith Administrators, and several smaller organizations. Some questionnaire recipients shared the questionnaire with related entities with a role in the insurance or administrative market. The questionnaire was issued in the fall 2001, and nine responses were ultimately received. (See Appendix E for the questionnaire and Appendix F for a summary of findings as well as a "combined" response prepared by Mercer). The data again show a clear clustering of plan features and values, although the limited number of responses do not permit the estimation of their prevalence.

Mandated Benefits

The Revised Code of Washington defines a mandated benefit as a “coverage or [an] offering required by law to be provided by a health carrier to: a) cover a specific health care service or services; b) cover treatment of a specific condition or conditions; or c) contract, pay, or reimburse specific categories of health care providers for specific services... .” This definition also requires insurers to propose other benefits (mandated offerings) to plan sponsors who, in turn, may choose not to include them in their benefit plans. Although the law addresses many other requirements for risk-bearing entities (e.g., with regard to loss ratios, disclosure of information, contract language), for purposes of this analysis these other requirements would be considered administrative or insurance mandates rather than benefit mandates.

A listing of current Washington benefit mandates is provided in Appendix G. Some insured plans are exempted from certain mandates—so called “value plans.” However, Office of Insurance Commissioner information (2002) indicates these plans are not being offered anywhere in Washington and that there is little demand for them (no causal order described). Insurers suggest that such value plans could indeed make insurance more affordable and accessible to employers and individuals whose lack of insurance is driven by economics (see next section); however, this suggestion runs counter to the low market demand evidenced for these plans and the unsubsidized portion of Basic Health.

On the whole, benefit mandates directly affect insured plans, although specific mandates of the state apply to certain public plans (e.g., Basic Health), and certain federal mandates apply to all plans (e.g., with regard to mental health benefits, mastectomy benefits, and benefits for new mothers and their newborns). Acceptance of benefit mandates varies. From a general perspective, mandated benefits might be seen as forming the basis of a model plan design. However, some insurers, employers, and health industry critics see benefit mandates as symptoms of unnecessary regulatory intervention, drivers of health care costs, or evidence of political favoritism, often being adopted without full evaluation of their effectiveness or financial effects. Other organizations and individuals, notably certain provider groups and patient advocacy organizations, consider the mandates that favor them as just and necessary. And, despite the fact that state mandates do not apply to self-insured plans, many mandates are voluntarily incorporated into non-insured plans, as a way to maintain the “competitiveness” of those plans and employers’ overall benefit packages. (Also see the report on “Market and Regulatory Reforms.”)

Accordingly, although benefit mandates may raise the benefit ceiling and costs for some plans, they may also become a floor for others. Information reviewed for this paper, as well as for the “Market and Regulatory Reforms” report of this project, suggest that changes in mandates would not necessarily distill, simplify, or reduce the costs of health coverage.

Payer Focus Group and Interviews

Mercer invited representatives of the ten organizations that had been asked to participate in the local survey of medical plan benefit packages/products to a meeting to discuss opportunities for benefit simplification as a means to improve access to health insurance coverage. One organization refused to participate in the study in any manner, disputing the basic premise of benefit distillation,

seeing it as counter to its business strategy. Other organizations were willing to participate in the meeting (focus group) or in separate telephone interviews. Ultimately, we received comments from representatives of Group Health Cooperative of Puget Sound, CIGNA HealthCare, and Regence Blue Shield.

Most comments were generated in light of a review of the project and the general findings of the payer survey as of the date the payer focus group session was held. Participants were asked if the preliminary findings of the survey were consistent with their knowledge of the marketplace, or if not, how they differed. The participants found the survey summary to meet their expectations with regard to typical deductibles, coinsurance and co-pay levels, exclusions and other features. The participants then discussed a series of issues affecting the health care marketplace as a whole, the value (if any) of simplifying benefits, and ways to expand access to health insurance for the uninsured. The major points made in these discussions follow.

Where is the health care and health insurance marketplace going?

- Continued cost escalation, that may “plateau” (flatten at a higher level).
- Ongoing increases in provider charges to some extent to allow providers to “catch up” on revenues not available in recent years because of managed care restrictions.
- Increases in procedures performed and billed. This can be explained, to some extent, by the availability of new technologies and direct-to-consumer advertising, which spurs demand. Demand will also necessarily grow as the population ages.
- A reversal of managed care cost-shifting practices (to providers of care) back to insurers to employers to plan participants.
- Excess provider capacity in the marketplace due to new technologies and drugs that change needs or demands for certain services (e.g., inpatient hospital care).
- Movement by larger employers to self-insured plans due to the ability to design most benefit features to be responsive to their workforce demands. (There was little discussion of other reasons for self-insuring, including explicit avoidance of benefit mandates, premium taxes, and carrier risk charges.)
- Movement by larger employers from local to national plans. (The participants suggested that local plans would no longer be competitive on issues of price or other features.)
- Limited movement to HMOs, particularly by individuals and small employers, because HMOs’ rules and policy are viewed as restrictive, although they do help to manage care and costs. Because of the nature of the populations remaining in HMO plans, local HMOs will see a rise in bad risk.
- Elimination by national carriers of their HMO plans, because they cannot manage them and because they will need to eliminate “loss leaders.”
- Continued “MTV style” health care marketing (specific lifestyle drugs, vision correction surgery, full-body scanning for “benchmarking” purposes rather than diagnosis). This type of marketing may miscommunicate the notion of quality of care.

- Continued enrichment of benefits due to additional mandates, evolving consumer demands (e.g., for alternate care service coverage), and sponsor/insurer maintenance of features that do not address rising costs (e.g., current deductibles).

How are payers going to respond to the market changes?

The participants suggested that all payers are “spinning around” (looking around to get a more complete sense of changes and appropriate responses). One or more suggested that many of the following options would be considered, if not actually implemented.

Utilization/Demand Management

- Evaluation of services and procedures with regard to their effect on quality of life, and additional education about them. Evaluation (and the promulgation of findings) may be supplemented with actual treatment protocols (standards).
- Some type of rationing (of services or benefits) as is used in the United Kingdom and in the Oregon Medicaid program
- Selected use of staff model HMO arrangements
- Evolution of other HMO plans into point-of-service plans requiring higher participant contributions toward premiums and higher cost sharing at time of service for out-of-network services.
- Information sharing (including consumer education) to foster controlled and appropriate benefit use.
- Discontinuation of efforts to pre-authorize initial diagnostic visits to general and specialist providers, but stronger efforts to manage follow-up care and intervene in costly diseases
- Education of consumers about providers’ treatment outcomes (e.g., mortality rates) and costs. (The group acknowledged that this had been tried earlier and was subject to misuse and misinterpretation.)

Plan Design

- Limited benefit distillation, as is already being seen with prescription drug formulary use and cost sharing, emergency room visit copayments, etc. However, the participants suggested that this would more likely be the result of recently promulgated requirements stemming from the federal Health Insurance Portability and Accountability Act, rather than other causes. The participants believe that payers can readily handle the administration of varying benefit designs because of sophisticated claim systems. Although they acknowledged that simplification of benefit designs might be helpful to providers and participants, they did not believe there is any compelling demand for this potential change.
- Some “leaner” products of different forms, such as
 - Reasonably comprehensive plans without benefit mandates (assuming changes can be made to insurance law throughout the country)
 - Catastrophic, safety net, or thrift plans sold at relatively low cost. These would include one or more of the following features:

- Very high deductibles
- Having plans where every benefit is subject to the deductible.
- Most covered services subject to considerable cost-sharing requirements until an out-of-pocket limit is reached and thereafter covered in full.
- Tighter screening (medical underwriting) of individual and small-group applicants
- Increased rating flexibility for the individual and small group market

The payer representatives noted that the participation in leaner plans might require:

- Tax support/government subsidies (e.g., To subsidize purchase by low income persons)
- Increased adoption of medical spending accounts
- Changes in federal tax law regarding health care flexible spending accounts
- Changes in state insurance law
- Maintenance of the “high risk pool” (Washington State Health Insurance Pool)

The market would also need to develop new supplemental medical plans and plans that could be marketed to individuals and families through employers without employer contributions required (i.e., payroll deduction only).

How can access to health insurance be expanded?

The participants suggested that further consideration be given to the following ideas. Some of these reflect ideas mentioned earlier or policy options that are being considered in other parts of this project.

- Reducing payroll taxes to employers offering and contributing toward their workforces’ health coverage (essentially an employer subsidy)
- Developing “stripped down” (catastrophic, safety net, and thrift) plans, along with all the regulatory and market changes required to make them sustainable
- Continuing Basic Health, with rules to prevent anti-selection by participants when they are at risk of claim. Specific suggested modifications included:
 - Limiting the pregnancy benefit if a woman defers enrollment until she is already pregnant
 - Limiting transplantation benefits
 - Requiring multi-year enrollment unless other insurance becomes available to the participant
 - Determining an affordable premium(s) and designing plans accordingly (one or more “BH Lite” products)

Summary of Payer Opinions

The participants were sympathetic to the state's concern about expanding health insurance coverage and tried to maintain this issue in the forefront of their discussion. Nevertheless, they noted that the uninsured population is not the primary group that they consider in their daily operations or longer-

term strategy. Furthermore, we must stress that the payer opinions and ideas referenced are few in number.

The payer representatives clearly indicated that distillation of benefits or other options such as the design and offering of thrift plans might only be actualized in the best of all possible worlds. Private insurers, administrators, and other organizations dealing with health coverage are constrained in the area of benefit design because of:

- Their own imperatives (e.g., marketing advantages provided by being flexible about plan design, risk reduction through careful underwriting and rating)
- Market demands (e.g., for first dollar coverage of wellness care)
- Regulatory constraints (e.g., state and federal benefit mandates, state rating rules)

They do not see benefit distillation as a major avenue toward increasing access to health insurance.

Issues in the Standardization of Medicare Supplement Products

In 1992, 10 common plan design options (Plans A to J) for Medicare Supplement (“Medigap”) plans were adopted across the United States in direct response to the Omnibus Budget Reconciliation Act (OBRA) of 1990, although previous legislation had been moving the Medicare Supplement market in this direction. Medigap plans are offered on a voluntary, self-pay basis to Medicare-eligible persons. The plans provide benefits for covered expenses not paid by Medicare (e.g., annual deductibles, hospital coinsurance) and, in some cases, provide benefits for services not covered by Medicare at all (e.g., outpatient prescription medications). Lobbying for standardization was led by AARP (a senior advocacy group formerly known as the American Association of Retired Persons) and Families USA, a consumer advocacy group. The legislative effort was led by Senator Claude Pepper (D-FL), Representative John Dingall (D-MI), and Senator Ted Kennedy (D-MA). Some states also backed this effort based on their experience with elderly insurance consumers.

Consumer protection of the elderly served as the primary reason Medigap standardization was sought, and both the literature on this issue as well as participants in the development of Medicare Supplement models indicate that standardization was not expected to yield direct cost savings. Standardization was intended to:

- Prevent unnecessary duplicate purchasing of supplemental coverage by seniors concerned about their health and their health care bills
- Eliminate “policy twisting” (sale of replacement plans) by agents seeking new sales commissions
- Discourage the development and sale of policies of limited or unclear value
- Encourage “apples to apples” comparison of policies, with competition clearly based on price

Neither the published literature on Medicare Supplement standardization, nor the persons interviewed, indicate that there was any specific economic reason for the standardization effort, per se. However, to ensure the success of Medigap plans, certain ancillary requirements were also enacted with regard to pricing and cost control (minimum loss ratios), protection of participants/enrollees from abandonment by carriers (rules regarding carrier entry into and exiting from the Medigap market), the provision of an extended open enrollment period upon initial entry into Medicare, pre-existing condition limitation caps, market conduct by agents, and full disclosure.

The National Association of Insurance Commissioners led the effort to develop the Medicare Supplement plans, with in-depth involvement by a handful of states, including Washington. To begin the Medigap distillation effort, the NAIC group asked carriers to send in their in-force Medicare Supplement plans. Designated members of the NAIC working group reviewed the plans, categorizing their components (e.g., skilled nursing facility benefits), and then arraying the plans and their actual benefits in a matrix (spreadsheet). This matrix was later refined to simplify the marketing and communicating of the benefits of Plans A-J. Some of the individuals involved in the initial development of the Medicare Supplement plans indicated that the plans submitted by the carriers varied surprisingly little to begin with. Real plan design difficulties only arose in terms of the inclusion of certain benefits, notably home care and preventive screening (due to the carriers' limited experience with these services). Prescription drug benefits also presented a challenge, as likely benefit costs were not known; accordingly, the prescription drug benefit was ultimately limited. Respondents also noted that they sought to define fewer than 10 plans, as would have been allowed by OBRA, but encountered carrier pressures to maximize consumer choice. Additionally, some carriers insisted on having Medigap plans modeled on existing plans.

Once the 10 plan designs were adopted, each state was required to approve Plan A at a minimum, the benefit plan with the lowest benefits but the most affordable premium. A few states were granted exceptions to these requirements, based on the existence of their own standards for Medicare Supplement plans; others were required to adopt the national standard, albeit with certain exceptions (e.g., rating) or have the Medigap policies in their jurisdictions come under federal regulation. Certain legally authorized and federally supported challenges have been made to Medicare Supplement plans, notably the Medicare+Choice programs of HMOs around the country. Except for the requirement that these plans must at minimum provide Medicare-equivalent benefits, they are not standardized, are not consistently available in all marketplaces, and are not as well understood by consumers (Fox et. al., 1999).

The 10 Medigap plans remain unchanged and appear to be well accepted. The reasons for the perceived value of and support for standard Medicare Supplement policies include:

- Simplicity, practicality, and straightforwardness.
- A well-reasoned purpose (anti-fraud, pro-consumer) with no perceivable economic motive benefiting anyone other than the consumer. (Interview participants also suggested that the potential cost savings associated with standardization would be modest, if any.)
- Reasonable compromises and ongoing consensus-building to accommodate the needs/demands of both consumers and insurers and to balance paternalism and laissez-faire.
- Trusted leadership (championing) of the effort.

With regard to Washington’s potential standardization of non-Medigap policies, Medicare Supplement experts noted that:

- It may be more difficult to determine common features among non-senior plans in the market with which to build a limited set of designs.
- At this point in time, special attention will be needed to determine the “right [basic] policy.” What benefits are appropriate given the speed with which the health care delivery system’s capabilities are evolving?
- The need to find money to subsidize the coverage or care of the poor would remain.
- Standardization, if pursued, will need to be accompanied by rules for underwriting, pricing, opting in and out by consumers, opting in and out of the marketplace by carriers, and other issues.

Appendix B

TREbase Data on Values of Selected Plan Design Elements—By Plan Type

The table in this appendix provides the most prevalent values of particular features/elements of medical plans by type of plan, the percentage of plans of each type with those values, and the number of responding plans concerning each feature. For example, the most common annual deductible for individuals covered by point-of-service (POS) plans who use non-network providers was \$300. This value (\$300) was reported by 27% of the 446 POS plans for which data were available.

	UNITED STATES EMPLOYERS									
	Indemnity		PPO Plan		HMO Plans		POS Plans		All Plans	
Medical Package Feature	Value	Total #	Value	Total #	Value	Total #	Value	Total #	Value	Total #
	%	of Plans	%	of Plans	%	of Plans	%	of Plans	%	of Plans
Cost Sharing										
Annual Individual Deductible	N/A		\$0		\$0		\$0		\$0	
Network			32%	837	99%	636	90%	457	68%	2018
Annual Individual Deductible	\$200		\$200 & \$250		N/A		\$300		\$200	
Non-Network	21%	617	17% each	828			27%	446	17%	1901
Annual Family Deductible	N/A		\$0		\$0		\$0		\$0	
Network			34%	836	99%	635	90%	457	70%	2016
Annual Family Deductible	\$600		\$600		N/A		\$600		\$600	
Non-Network	15%	613	15%	827			16%	445	15%	1895
Lifetime Maximum Base Plan	N/A		Unlimited		Unlimited		Unlimited		Unlimited	
Network			35%	831	91%	611	66%	447	60%	1984
Lifetime Maximum Base Plan	\$1,000,000		\$1,000,000		N/A		\$1,000,000		\$1,000,000	
Non-Network	43%	633	40%	837			41%	446	40%	1927
Out-of-Pocket Limit*	N/A		\$1000 & \$1500		N/A		N/A		N/A	
Individual Network			12%	830	64%	619	52%	451	39%	1991
Out-of-Pocket Limit	\$1,500		\$2,000		N/A		\$3,000		\$2,000	
Individual Non-Network	10%	617	9%	828			14%	441	9%	1897
Out-of-Pocket Limit ¹	N/A		N/A		N/A		N/A		N/A	
Family Network			19%	827	65%	615	55%	448	43%	1981
Out-of-Pocket Limit ¹	N/A		N/A		N/A		N/A		N/A	
Family Non-Network	21%	612	12%	826			11%	439	15%	1888
Plan Feature										

* "\$0" out-of-pocket limits in TREbase have been listed as N/A.

Options for Distilling the Current Array of Washington State Medical Benefit Packages

19

Project funded by the U.S. Department of Health and Human Services, Health Resources and Services Administration's Bureau of Professions State Planning
Grant #1 P09 OA 00002-01

Appendix B (continued)
TREbase Data on Values of Selected Plan Design Elements—By Plan Type

	UNITED STATES EMPLOYERS									
	Indemnity		PPO Plan		HMO Plans		POS Plans		All Plans	
Medical Package Feature	Value	Total #	Value	Total #	Value	Total #	Value	Total #	Value	Total #
	%	of Plans	%	of Plans	%	of Plans	%	of Plans	%	of Plans
Inpatient Hospital	N/A		10%		0%		0%		0%	
Coinsurance % Network			41%	794	96%	469	63%	344	51%	1665
Inpatient Hospital	20%		30%		N/A		30%		20%	
Coinsurance % Non-Network	68%	642	39%	848			47%	459	39%	1959
Office Visit Copay	N/A		\$10		\$10		\$10		\$10	
Network			44%	577	60%	586	57%	422	53%	1662
Office Visit Copay	\$15		\$10		N/A		\$15		\$10	
Non-Network	42%	29	25%	24			37%	11	32%	64
Emergency Room Copay	N/A		\$50		\$50		\$50		\$50	
Network			64%	381	48%	539	54%	362	55%	1348
Emergency Room Copay	\$50		\$50		N/A		\$50		\$50	
Non-Network	61%	81	64%	306			55%	244	59%	637
Inpatient Hospital	N/A		\$100		\$100		\$100		\$100	
Copay Network			34%	98	32%	176	33%	142	33%	450
Inpatient Hospital	\$150		\$250		N/A		\$250		\$250	
Copay Non-Network	20%	45	26%	184			35%	66	26%	296
Prescription Drug										
Brand Name Copay	N/A		\$15		\$25		\$15		\$15 & \$25	
Network			18%	657	23%	488	19%	356	17% each	1845
Brand Name Copay	\$15		\$15		N/A		\$25		\$15	
Non-Network	21%	177	17%	268			21%	104	18%	586
Generic Copay	N/A		\$5		\$5		\$5		\$5	
Network			36%	676	45%	596	51%	388	42%	2020
Generic Copay	\$10		\$10		N/A		\$5		\$10	
Non-Network	34%	177	34%	275			43%	112	32%	609

Appendix B (continued)
TREbase Data on Values of Selected Plan Design Elements—By Plan Type

	WASHINGTON STATE EMPLOYERS									
	Indemnity		PPO Plan		HMO Plans		POS Plans		All Plans	
Medical Package Feature	Value	Total #	Value	Total #	Value	Total #	Value	Total #	Value	Total #
	%	of Plans	%	of Plans	%	of Plans	%	of Plans	%	of Plans
Cost Sharing										
Annual Individual Deductible	N/A		\$200		\$0		\$0		\$0	
Network			6	19	18	18	9	9	29	48
Annual Individual Deductible	\$100		\$200		N/A		\$500		\$200	
Non-Network	2	11	7	19			3	9	9	40
Annual Family Deductible	N/A		\$300 & \$500		\$0		\$0		\$0	
Network			4 each	19	18	18	9	9	30	48
Annual Family Deductible	\$300		\$500 & \$600		N/A		\$900 or \$1500		\$300	
Non-Network	2	11	4 each	19			2 each	9	7	40
Lifetime Maximum Base Plan	N/A		\$1,000,000		Unlimited		Unlimited		Unlimited or \$1,000,000	
Network			13	20	12	18	4	9	20 each	49
Lifetime Maximum Base Plan	\$1,000,000		\$1,000,000		N/A		Unlimited or \$1,000,000		\$1,000,000	
Non-Network	9	13	13	20			4 each	9	27	43
Out-of-Pocket Limit	N/A		\$1,500		\$0		\$0 or \$750		\$0	
Individual Network			6	20	7	18	3 each	8	10	48
Out-of-Pocket Limit	\$1,000		\$0		N/A		\$3,000		\$3,000	
Individual Non-Network	3	13	4	20			4	9	7	44
Out-of-Pocket Limit	N/A		\$0		\$0		\$0		\$0	
Family Network			6	20	7	18	3	8	16	48
Out-of-Pocket Limit	\$2,000, \$3,200 & \$4,500		\$0		N/A		\$0		\$0	
Family Non-Network	2 each	13	10	20			3	9	13	44
Plan Feature										
Inpatient Hospital	N/A		10%		0%		0%		0%	
Coinsurance % Network			7	17	11	11	6	6	18	35
Inpatient Hospital	20%		30%		N/A		30%		20%	
Coinsurance % Non-Network	12	13	4	19			5	9	15	42

Options for Distilling the Current Array of Washington State Medical Benefit Packages

21

Appendix B (continued)

TREbase Data on Values of Selected Plan Design Elements—By Plan Type

	WASHINGTON STATE EMPLOYERS									
	Indemnity		PPO Plan		HMO Plans		POS Plans		All Plans	
Medical Package Feature	Value	Total #	Value	Total #	Value	Total #	Value	Total #	Value	Total #
	%	of Plans	%	of Plans	%	of Plans	%	of Plans	%	of Plans
Office Visit Copay	N/A		\$10		\$10		\$10		\$10	
Network			5	11	13	16	7	9	26	37
Office Visit Copay	N/A		N/A		N/A		\$10		\$10	
Non-Network							1	1	1	1
Emergency Room Copay	N/A		\$50		\$50		\$50		\$50	
Network			7	12	10	14	5	7	23	34
Emergency Room Copay	\$25		\$50		N/A		\$50		\$50	
Non-Network	3	3	6	10			2	5	8	18
Inpatient Hospital	N/A		\$100		\$100		\$100		\$100	
Copay Network			2	3	6	7	3	3	12	14
Inpatient Hospital	\$250		\$100 & \$250		N/A		\$250		\$250	
Copay Non-Network	1	1	1 each	2			2	2	4	5
Prescription Drug										
Brand Name Copay	N/A		\$7, \$10, \$20, \$30		\$10 and \$30		\$5 or \$10		\$10	
Network			3 each	15	3 each	12	2	7	11	41
Brand Name Copay	\$30		\$10		N/A		\$10		\$30	
Non-Network	1	1	2	7			2	4	5	12
Generic Copay	N/A		\$5		\$5		\$5		\$5	
Network			8	15	8	15	5	8	25	45
Generic Copay	\$7		\$5		N/A		\$5		\$5	
Non-Network	1	1	3	7			2	4	5	12

Appendix C

Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans 2000

Most Frequent Values of Employer-Sponsored Medical Packages 2000 – Large Employers

NATIONAL LARGE EMPLOYERS:*

- PPO 75%
- HMO 51%
- POS 29%
- Indemnity 25%

WASHINGTON LARGE EMPLOYERS*

- PPO 85%
- HMO 71%
- POS 44%
- Indemnity 23%

Medical Package Feature	UNITED STATES EMPLOYERS				WASHINGTON STATE EMPLOYERS			
	PPO	HMO	POS	Indemnity	PPO	HMO	POS	Indemnity
Median Deductible:								
Hospital Individual		\$200						
Individual In-Network	\$250		\$250		\$200		ID†	
Individual Out-of-Network	\$300		\$300		\$200		\$250	
Family In-Network	\$600							
Family Out-of-Network	\$750		\$750					
Median Office Visit Copay	\$10	\$10	\$10		\$10	\$11	\$10	
Median In-Network Coinsurance	20%							
Median Out-of-Network Coinsurance	30%		30%		35%		30%	
Median Out-of-Pocket Maximum				\$1,500				\$1,500
Median In-Network Out-of-Pocket Maximum	\$1,250		\$1,000					
Median Out-of-Network OOP Maximum	\$2,000		\$2,400					
Percentage of Employers Providing:								
Prescription Drug Card Plans	80%	75%	78%	73%				
Prescription Mail Order Plans	82%	81%	81%	78%				
Chiropractic	84%	66%	81%	84%				

* Percents do not total 100 due to multiple responses.

† ID = Insufficient Data.

Most Frequent Values of Employer-Sponsored Medical Packages 2000 – Small Employers

SMALL EMPLOYERS:*

- PPO 47%
- HMO 38%
- POS 19%
- Indemnity 14%

	UNITED STATES EMPLOYERS				WASHINGTON STATE EMPLOYERS			
Medical Package Feature	PPO	HMO	POS	Indemnity	PPO	HMO	POS	Indemnity
Median Deductible:					Information not available			
Hospital		\$250						
Individual				\$350				
Individual In-Network	\$250							
Individual Out-of-Network	\$300		\$500					
Family				\$500				
Family In-Network	\$700							
Family Out-of-Network	\$750		\$800					
Median Office Visit Copay	\$10	\$11	\$10					
Median In-Network Coinsurance	10%							
Median Out-of-Network Coinsurance	25%		20%					
Median Out-of-Pocket Maximum				\$1,500				
Median In-Network Out-of-Pocket Maximum	\$1,500		\$1,500					
Median Out-of-Network OOP Maximum	\$2,250		\$2,500					
Percentage of Employers Providing:								
Prescription Drug Card Plans	85%	82%	86%	81%				
Prescription Mail Order Plans	71%	65%	64%	63%				
Chiropractic	77%	66%	65%	79%				

* Percents do not total 100 due to multiple responses.

Appendix D

The Robert Wood Johnson Foundation Employer Health Insurance Survey

Plan Design Features of Medical Plans Offered by Washington State Employers

The Robert Wood Johnson Foundation Employer Health Insurance Survey			
	Small Groups (less than 50 employees)	Insured Large Groups	Self-Insured Large Groups
Number of group plans (unweighted)	487	352	146
Share of enrollment (across all groups) (100%)	26.0%	41.0%	33.0%
Deductibles			
Top 3 deductibles and associated share of enrollment within size group	74.4%	92.2%	91.1%
Amount	\$0	\$0	\$0
Share of enrollment (within size group)	41.8%	48.5%	40.5%
Amount	\$200	\$200	\$100
Share of enrollment (within size group)	22.2%	35%	35.9%
Amount	\$250	\$100	\$200
Share of enrollment (within size group)	10.4%	8.7%	14.7%

The Robert Wood Johnson Foundation Employer Health Insurance Survey			
In-Network Cost-Sharing			
<i>Coinsurance – in-network</i>			
Share with coinsurance (or no cost-share) (employees within size group)	74.3%	73.0%	59.3%
Share of total group enrollment	19.3%	29.9%	19.6%
Top 3 coinsurance rates			
Amount	20%	20%	10%
Share of enrollment (within size group with coinsurance)	30.5%	47%	43.5%
Amount	0%	30%	20%
Share of enrollment	24%	21.8%	28.8%
Amount	30%	10%	0%
Share of enrollment	20.9%	18.6%	14.5%
<i>Copayment – in-network</i>			
Share with copayment (employees within size group)	25.7%	27.0%	40.7%
Share of total group enrollment	6.7%	11.0%	13.4%
Top 3 copayment rates			
Amount	\$10	\$5	\$10
Share of enrollment (within size group with copayment)	73.0%	64.5%	78.7%
Amount	\$5	\$10	\$5
Share of enrollment	17.3%	33.7%	17.5%
Amount	\$25	\$15	\$25
Share of enrollment	4.5%	1.7%	3.0%
<i>Catastrophic Cost Protection</i>			
Individual out-of-pocket maximum*			
Share with maximum (employees within size group with maximum)	71.2%	71.9%	81.5%
Top 3 maximums			
Amount	\$1,000	\$1,000	\$500
Share of enrollment (within size group)	27.1%	25.5%	30.1%
Amount	\$2,000	\$500	\$750
Share of enrollment	16.0%	15.5%	17.9%
Amount	\$1,500	\$750	\$1,000
Share of enrollment	11.5%	12.1%	15.6%

* Among self-insured top two maximums, few actual observations but groups had many employees.

The Robert Wood Johnson Foundation Employer Health Insurance Survey			
Out-Of-Network Cost-Sharing			
Out-of-network for PPO/POS			
Share in PPO/POS (employees within size group)	53.4%	32.4%	63.4%
Out-of-plan Coinsurance			
Share with coinsurance (or no cost-share) (PPO/POS employees within size group)	46.6%	32.5%	34.6%
Top 3 coinsurance rates			
Amount	20%	30%	40%
Share of enrollment (within size group with coinsurance)	36.3%	26.7%	83.3%
Amount	40%	25%	30%
Share of enrollment	30.5%	22.2%	11.3%
Amount	30%	20%	20%
Share of enrollment	22.5%	21.9%	3%
Out-of-plan Copayments			
Share with copayment (PPO/POS employees within size group)	53.4%	67.5%	65.4%
Top 3 copayments			
Amount	\$10	\$10	\$20
Share of enrollment (within size group with copayment)	35.3%	68.5%	56.6%
Amount	\$25	\$15	\$10
Share of enrollment	21.9%	18.5%	19.9%
Amount	\$15	\$5	\$15
Share of enrollment	20.7%	5.5%	17.3%

The Robert Wood Johnson Foundation Employer Health Insurance Survey			
Prescription Drug Cost-Sharing			
Share with drug coverage (employees within size group)	94.8%	99.5%	97.1%
Coinsurance			
Share with coinsurance (of those with drug coverage)	51.5%	41.0%	41.1%
Top 3 coinsurance rates			
Amount	20%	20%	10%
Share of enrollment (within size group with coinsurance)	32.5%	33.9%	47.1%
Amount	0%	30%	20%
Share of enrollment	28.7%	27.0%	27%
Amount	30%	10%	0%
Share of enrollment	15.0%	24.2%	15%
Copayments			
Share with copayment (of those with drug coverage)	48.5%	59.0%	58.9%
Top 3 copayment rates			
Amount	\$10	\$5	\$10
Share of enrollment (within size group with copayment)	54.1%	49.9%	69.3%
Amount	\$5	\$10	\$5
Share of enrollment	22.8%	29.9%	21.1%
Amount	\$7	\$8	\$25
Share of enrollment	7.1%	9.8%	2.9%

Appendix E

Washington State Planning Grant on Access to Health Insurance Private Payer Questionnaire

Name of Payer: _____ Contact Person: _____ Title of Contact: _____

Telephone Number: _____ Fax Number: _____ Email Address: _____

1. Please provide the following information about your private clientele in the State of Washington.

	Private Products Your Organization Insures				Private Products Your Organization Administers Only			
	Individual	Small Group	Large Group Products		Individual	Small Group	Large Group Products	
	Products	Products	Insured	Self- Insured	Products	Products	Insured	Self- Insured
Number of private benefit packages or plan designs								
Number of plan sponsors*	N/A				N/A			
Number of subscribers								
Covered members								
With no other insurance								
With other insurance								
Total								
Names of largest private benefit package/plan sponsors	N/A				N/A			

* E.g., private employers.

2. On what basis does your organization define a “plan” or “product” as separate from other plans or products? *(Please check all applicable responses.)*

- ☐ Unique benefit package
- ☐ Separate plan sponsor(s)
- ☐ Specific other features (e.g., access to restrictive provider networks in certain locations)
- ☐ Other *(Please specify.)*

3. What mechanisms does your organization use to identify different private plans? *(Please check all applicable responses.)*

- ☐ Unique plan identifiers (ID codes)
- ☐ Separate contracts
- ☐ Dedicated account representatives or teams
- ☐ Other *(Please specify.)*

4. What services are generally not included as covered benefits in private products? (*Please check all applicable responses.*)

Services Generally Not Covered (Excluded)	Individual	Small Group	Large Group Products	
	Products	Products	Insured	Self-Insured
Basic vision benefits				
Care provided by relatives or household members				
Care that is the responsibility of another party, or covered under workers compensation				
Governmental services or services covered by (other) governmental plans				
Cosmetic services				
Dental care				
Experimental services				
Infertility-related care				
Private nursing				
Rental or purchase of luxury durable medical equipment				
Special education				
Other (<i>Please specify.</i>)				

5. Please show the most common non-prescription drug benefit features included in your private plans:

	Individual Products			Small Group Products			Large Group Products					
	First Most Common	Second Most Common	Third Most Common	First Most Common	Second Most Common	Third Most Common	Insured			Self-Insured		
							First Most Common	Second Most Common	Third Most Common	First Most Common	Second Most Common	Third Most Common
Deductibles												
Per individual	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
Per family	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
Coinsurance levels	%	%	%	%	%	%	%	%	%	%	%	%
Copays												
Office visit	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
Hospital admission	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
Other <u>non-drug</u> (Please specify.)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
Internal plan limits on days, visits, procedures, dollars or other												
Mental health care	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
Chemical dependency care	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
Home health care	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
Skilled nursing facility care	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
Rehabilitation services	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
Other <u>non-drug</u> (Please specify.)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
Plan maximums (per lifetime)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$

	Individual Products			Small Group Products			Large Group Products					
	First Most Common	Second Most Common	Third Most Common	First Most Common	Second Most Common	Third Most Common	Insured			Self-Insured		
							First Most Common	Second Most Common	Third Most Common	First Most Common	Second Most Common	Third Most Common
Annual out-of-pocket limits												
Per individual	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
▪ Per family	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$

6. What are your most frequent prescription drug cost-sharing approaches in private plans?

Private Plans	Individual Products		Small Group Products		Large Group Products			
	In-Network	Out-of-Network	In-Network	Out-of-Network	Insured		Self-Insured	
					In-Network	Out-of-Network	In-Network	Out-of-Network
Five most common cost-sharing arrangements (indicate brand vs. generic; formulary vs. non-formulary)								
First								
Second								
Third								
Fourth								
Fifth								

7. What are your most frequent in- and out-of-network benefit differentials in private plans?

Private Plans	Individual Products		Small Group Products		Large Group Products			
	In-Network	Out-of-Network	In-Network	Out-of-Network	Insured		Self-Insured	
					In-Network	Out-of-Network	In-Network	Out-of-Network

Private Plans	Individual Products		Small Group Products		Large Group Products			
					Insured		Self-Insured	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
A. Five most common coinsurance arrangements (e.g., 90%/70%)	e.g., 90%	e.g., 70%						
First								
Second								
Third								
Fourth								
Fifth								
B. Five most common copay arrangements (e.g., \$10/\$25)	e.g., \$10	e.g., \$25						
First								
Second								
Third								
Fourth								
Fifth								

8. Please outline your primary gatekeeper (utilization management) requirements, and the types of benefits affected. (*Please check all applicable items.*)

Private Plans	Individual Products	Small Group Products	Large Group Products	
	e.g., mandatory pre-admission certification		Insured	Self-Insured e.g., voluntary case management
Hospitalization				
Selected diagnosis				
Selected treatment				
Non-formulary				

Private Plans	Individual Products	Small Group Products	Large Group Products	
	<i>e.g., mandatory pre-admission certification</i>		Insured	Self-Insured <i>e.g., voluntary case management</i>
Other (<i>Please specify.</i>)				

9. With regard to your private group plans, please provide your minimum underwriting rules for insured groups.

Private Plans	Small Group (Insured)	Large Group (Insured)
Minimum number of hours employees must work to qualify for coverage	_____ hours per week	_____ hours per week
Minimum employer contribution toward employee coverage	_____ %	_____ %
Minimum employer contribution toward dependent coverage	_____ %	_____ %
Other (please summarize)		

10. What, if any are the major distinguishing features of private plans you offer in different parts of Washington?

Private Plans	Individual	Small Group	Large Group	
			Insured	Self-Insured
Northwest Washington				
Seattle Area				
Southwest Washington				
Northeast Washington				
Spokane Area				
Southeast Washington				

Private Plans	Individual	Small Group	Large Group	
			Insured	Self-Insured

11. From your organization's perspective, what are the reasons certain features, and variations among them, become commonplace or unusual? (*1=most important reason, 2=second most important reason, etc.*)

- Insurance mandates _____
- Marketplace demands _____
- Ease in administration _____
- Ease in communicating _____
- Other (*Please specify.*) _____

We ask that you please forward the following with your completed questionnaire no later than November 16, 2001 to:

Florence Katz
William M. Mercer, Incorporated
600 University Street, Suite 3200
Seattle, WA 98101

- Sample plan element worksheet (listing of benefits) used by your underwriters and actuaries to price plans.
- Sample plan implementation worksheets used to define or program adjudication rules (both manual and automatic).
- A rate sheet and associated benefit summary for your *individual* market plan:
 - Of highest benefit value with significant enrollment
 - With the highest enrollment
 - Of lowest benefit value with significant enrollment.
- A rate sheet and associated benefit summary for your *small group* market plan:
 - Of highest benefit value with significant enrollment
 - With the highest enrollment
 - Of lowest benefit value with significant enrollment.

Thank you for your cooperation. If you have any questions, please contact Florence Katz at 206 808 8469 or florence.katz@mercer.com.

Appendix F

Summary of Responses to Private Payer Questionnaire

About the Respondents

Nine responses: 2 national carriers, 1 health care service contractor, 4 third party administrators (TPAs) for self-insured plans, 1 TPA/provider network; 1 health maintenance organization (HMO)

Well over 14,500 plan sponsors represented (note: one major payer declined to provide this information)

Over 875,000 subscribers and 1,850,000 members covered.

General Findings

Relatively small number of plan designs offered, but there is a recognition that groups may have variations on these designs (note: one TPA indicated it administers 150 benefit packages [plan designs]). Plans/products are defined by having

- differentiated benefit packages and plan sponsors
- specific other features (special network, gatekeeper, or referral requirements)
- different ID/plan codes, contracts; sometimes account representatives and structures

Many organizations have difficulty providing counts of members with and without dual coverage

Typical exclusions

- | | |
|----------------------------|--|
| ➤ cosmetic services | ➤ infertility care |
| ➤ dental care | ➤ luxury DME |
| ➤ experimental care | ➤ private nursing |
| ➤ family-provided services | ➤ special education |
| ➤ government services | ➤ workers compensation/third party liability |

Unweighted deductible, coinsurance and copayment amounts (generally listed in order of frequency within top three payer-specified amounts). Please note that these listings are based on small number of responses, and incomplete responses from some payers.

- most common deductibles – individual
 - individual, insured plans \$500, \$1,000
 - small group, insured \$500, \$200
 - large group, insured \$300, \$200*
 - large group, self-insured \$0, \$200, \$300¹
- most common deductibles – family
 - individual, insured plans \$1,500, \$3,000
 - small group, insured \$600, \$1,500
 - large group, insured \$600
 - large group, self-insured \$600, \$300

Coinsurance generally 80%/20% to 100%/0%, with 20% differential if PPO plan

* If POS plan, these deductibles would apply only to out-of-network services.

Copayments

- office visits – \$10, \$15, \$20
- hospital admission – primarily \$250 per admission or \$100/per day for up to three days
- emergency room visits – \$50 or \$75 per visit

Benefit limits

- mental health
 - outpatient – 10–50 visits, generally 20 visits
 - inpatient – 8–45 days, generally 30 days
- chemical dependency
 - 30–60 days/visits
 - \$10,000–\$11,000 every two years (per WA State law)
- home health care – 130 visits
- skilled nursing facility
 - if defined by utilization, 30, 60 or 90 days per year
 - frequently only in lieu of hospitalization
- rehabilitation
 - if defined by utilization, 60 days/visits or 90 days per year
 - if defined by payment, \$1,500 per year for outpatient rehabilitation and \$30,000 per condition
- policy maximum – unlimited, \$1,000,000, \$2,000,000

Annual out-of-pocket limited (in-network)

- individual – \$2,000, \$1,000
- family – \$6,000, with range from \$0 to \$7,500

Prescription drug cost sharing

- little use of closed formularies
- main generic copays – \$5, \$10, or \$15
- main formulary brand copays – \$10 and \$20
- non-formulary brand copays – \$25 or more

Utilization management

- still some focus on pre-admission certification and other inpatient review techniques
- disease/case management
- for drugs, voluntary formularies, step therapy requirements

Underwriting requirements for groups (except for Taft-Hartley groups)

- minimum hours – 17.5 hours per week (minimum); generally ranges from 17.5 to 30; Taft-Hartley groups may use monthly requirement
- Employer contribution
 - for employees – 50% to 75%
 - for dependents – 0% or 50%

Washington State Planning Grant on Access to Health Insurance

Combined Responses to Private Payer Questionnaire

1. Please provide the following information about your private clientele in the State of Washington.

	Private Products Your Organization Insures				Private Products Your Organization Administers Only			
	Individual Products	Small Group Products	Large Group Products		Individual Products	Small Group Products	Large Group Products	
			Insured	Self-Insured			Insured	Self-Insured
Number of private benefit packages or plan designs								
▪ Payer 1 ^{*†}		8 (1)	(2)			8 (1)		(2)
▪ Payer 2			Not Available					Not Available
▪ Payer 3		16	16					
▪ Payer 4	9	36	Unknown	3				
▪ Payer 5								150
▪ Payer 6					1			55
▪ Payer 7								4
▪ Payer 8 [‡]								
▪ Payer 9 [§]					0	16	1	27

* This data is not captured, but is commonly understood.

† Payer 1 does not specifically track this information, as the unique characteristics of large plan sponsors result in many plan design variations.

‡ Survey includes only Payer 8 products; does not include products of affiliates (third party administrators).

§ Because virtually all of the health plans Payer 9 administers have unique plan designs to meet the needs of each separate plan sponsor, it is difficult to be completely precise in the data presented. Payer 9 has defined “small group” as less than 500 eligible employees and “large group” as more than 500 eligible employees. There are no groups that Payer 9 insures.

	Private Products Your Organization Insures				Private Products Your Organization Administers Only			
	Individual Products	Small Group Products	Large Group Products		Individual Products	Small Group Products	Large Group Products	
			Insured	Self-Insured			Insured	Self-Insured
Number of plan sponsors*								
▪ Payer 1		2,122	2,706					47
▪ Payer 2			35					25
▪ Payer 3		5,000	164					
▪ Payer 4		3,127	1,100	3				
▪ Payer 5	N/A				N/A			90
▪ Payer 6								55
▪ Payer 7								4
▪ Payer 8	N/A				N/A			
▪ Payer 9						10	1	22
Number of subscribers								
▪ Payer 1		14,106	55,776					1,002
▪ Payer 2			4,505					85,592
▪ Payer 4	12,165	13,783	186,786	2,069				
▪ Payer 5								26,000
▪ Payer 6					2,500			36,000
▪ Payer 7								
▪ Payer 8	61,382	81,115	210,328					
▪ Payer 9						2,000	5,200	77,000
Covered members								
▪ With no other insurance								
– Payer 2			Not Available					Not Available
– Payer 4	0	22,320	367,596	3,918				
– Payer 5								49,200
– Payer 6					4,800			Unknown

* E.g., private employers.

	Private Products Your Organization Insures				Private Products Your Organization Administers Only			
	Individual Products	Small Group Products	Large Group Products		Individual Products	Small Group Products	Large Group Products	
			Insured	Self-Insured			Insured	Self-Insured
<ul style="list-style-type: none"> ▪ With other insurance <ul style="list-style-type: none"> – Payer 2 – Payer 4 – Payer 5 – Payer 6 ▪ Total <ul style="list-style-type: none"> – Payer 1 – Payer 2 – Payer 3 – Payer 4 – Payer 5 – Payer 6 – Payer 7 – Payer 8 			Not Available					Not Available
	18,734	437	15,316	163				
								3,800
					200			Unknown
		31,033	86,113					2,067
			9,461					179,742
			14,692					
	18,734	22,757	382,912	4,081				
								53,000
					5,000			75,000
								48,000
	92,073	136,076	427,968					262,672

	Private Products Your Organization Insures				Private Products Your Organization Administers Only			
	Individual Products	Small Group Products	Large Group Products		Individual Products	Small Group Products	Large Group Products	
			Insured	Self-Insured			Insured	Self-Insured
Names of largest private benefit package/plan sponsors								
▪ Payer 1*		(1)	(1)					(1)
▪ Payer 2								3 names withheld
▪ Payer 3		Association plans	1 name withheld					
▪ Payer 4		5 names withheld	6 names withheld	3 names withheld				
▪ Payer 5	N/A				N/A			1 name withheld
▪ Payer 6								1 name withheld
▪ Payer 7								4 names withheld
▪ Payer 8	N/A		1 name withheld		N/A			1 name withheld
▪ Payer 9						1 name withheld	1 name withheld	2 names withheld

* Information considered proprietary and not specifically tracked.

2. On what basis does your organization define a “plan” or “product” as separate from other plans or products? *(Please check all applicable responses.)*

Plan or Product	Payer 1	Payer 2	Payer 3	Payer 4	Payer 5	Payer 6	Payer 7	Payer 8	Payer 9
▪ Unique benefit package	X		X	X	X		X	X	X
▪ Separate plan sponsor(s)	X	X	X	X	X	X	X		X
▪ Specific other features (e.g., access to restrictive provider networks in certain locations)	X		X PCP 'gatekeeper' and referral requirement	X			X	X Provider network, product type plan code	X
▪ Other									Medical v. dental or vision

3. What mechanisms does your organization use to identify different private plans? *(Please check all applicable responses.)*

Mechanism	Payer 1	Payer 2	Payer 3	Payer 4	Payer 5	Payer 6	Payer 7	Payer 8	Payer 9
▪ Unique plan identifiers (ID codes)	X		X	X	X	X	X	X	X
▪ Separate accounts	X	X	X	X		X	X	X	X
▪ Dedicated account representatives or teams			X	X				X	X
▪ Other (please specify)	account structure								

4. What services are generally not included as covered benefits in private products? *(Please check all applicable responses.)*

Services Generally Not Covered (Excluded)	Individual Products	Small Group Products	Large Group Products	
			Insured	Self-Insured
Basic vision benefits				
▪ Payer 1				
▪ Payer 2				
▪ Payer 3		X	X	
▪ Payer 4 – We cover the exam only.				
▪ Payer 8	X	Optional coverage available	X	X
Care provided by relatives or household members				
▪ Payer 1		X	X	X
▪ Payer 2			X	X
▪ Payer 3		X	X	
▪ Payer 4	X	X	X	X
▪ Payer 5				X
▪ Payer 6	X			X
▪ Payer 7				X
▪ Payer 8	X	X	X	X
▪ Payer 9		X	X	X
Care that is the responsibility of another party, or covered under workers compensation				
▪ Payer 1		X	X	X
▪ Payer 2			X	X
▪ Payer 3		X	X	
▪ Payer 4	X	X	X	X
▪ Payer 5				X
▪ Payer 6	X			X
▪ Payer 7				X
▪ Payer 8	X	X	X	X
▪ Payer 9		X	X	X

Services Generally Not Covered (Excluded)	Individual Products	Small Group Products	Large Group Products	
			Insured	Self-Insured
Governmental services or services covered by (other) governmental plans				
▪ Payer 1		X	X	X
▪ Payer 2			X	X
▪ Payer 3		X	X	
▪ Payer 4	X	X	X	X
▪ Payer 5				X
▪ Payer 7				X
▪ Payer 8	X	X	X	X
▪ Payer 9		X	X	X
Cosmetic services				
▪ Payer 1		X	X	X
▪ Payer 2			X	X
▪ Payer 3		X	X	
▪ Payer 4	X	X	X	X
▪ Payer 5				X
▪ Payer 6	X			X
▪ Payer 7				X
▪ Payer 8	Limited coverage	Limited coverage	X	X
▪ Payer 9		X	X	X
Dental care				
▪ Payer 1		X	X	X
▪ Payer 2				
▪ Payer 3		X	X	
▪ Payer 4	X	X	X	X
▪ Payer 8	Optional coverage available	Optional coverage available	X	X

Services Generally Not Covered (Excluded)	Individual Products	Small Group Products	Large Group Products	
			Insured	Self-Insured
Experimental services				
▪ Payer 1*		X (1)	X (1)	X (1)
▪ Payer 2			X	X
▪ Payer 3		X	X	
▪ Payer 4	X	X	X	X
▪ Payer 5				X
▪ Payer 6	X			X
▪ Payer 7				X
▪ Payer 8	X	X	X	X
▪ Payer 9		X	X	X
Infertility-related care				
▪ Payer 1†		X (2)	X (2)	X (2)
▪ Payer 2			X	X
▪ Payer 3		X	X	
▪ Payer 4 – (exam only)	X	X	X	X
▪ Payer 5				X
▪ Payer 6	X			X
▪ Payer 7				X
▪ Payer 8	X	X	X	X
▪ Payer 9		X	X	X
Private nursing				
▪ Payer 1		Info. not provided	Info. not provided	Info. not provided
▪ Payer 2			X	X
▪ Payer 4	X	X	X	X
▪ Payer 8	X	X	X	X

* Experimental or investigational treatments not standardly covered.

† Standard benefit covers basic infertility services.

Services Generally Not Covered (Excluded)	Individual Products	Small Group Products	Large Group Products	
			Insured	Self-Insured
Rental or purchase of luxury durable medical equipment				
▪ Payer 1		X	X	X
▪ Payer 2			X	X
▪ Payer 3		X	X	
▪ Payer 4	X	X	X	X
▪ Payer 7				X
▪ Payer 8	X	X	X	X
▪ Payer 9		X	X	X
Special education				
▪ Payer 1	N/A	Info. not provided	Info. not provided	Info. not provided
▪ Payer 2			X	X
▪ Payer 3		X	X	
▪ Payer 8	X	X	X	X
▪ Payer 9		X	X	X
Other (<i>Please specify.</i>)				
▪ Payer 8 (not specified)	X	X	X	X

5. Please show the most common non-prescription drug benefit features included in your private plans:

	Individual Products			Small Group Products			Large Group Products					
	First Most Common	Second Most Common	Third Most Common	First Most Common	Second Most Common	Third Most Common	Insured			Self-Insured		
							First Most Common	Second Most Common	Third Most Common	First Most Common	Second Most Common	Third Most Common
Deductibles												
▪ Per individual												
– Payer 1				\$100	\$200	\$500	\$300	\$300	\$500	\$300	\$300	\$500
– Payer 2							\$200	\$0	\$300	\$200	\$0	\$300
– Payer 3				\$500	\$200		\$400	\$200				
– Payer 4	\$0	\$500	\$1,000	\$0	\$0	\$500						
– Payer 5										\$200	\$100	\$300
– Payer 6	\$200	\$300	\$500							\$200	\$300	\$100
– Payer 7										None/\$0/300	\$0	\$100
– Payer 8*	\$500	\$1,500	\$1,000	\$200	\$100	\$500	\$0/200	\$0/200	\$0/500	\$0/200	\$0/200	\$0/500
– Payer 9				\$200	\$300	\$500	\$150			\$0 in network	\$200 out-of-network	\$200 out-of-network
▪ Per family												
– Payer 1				\$300	\$600	\$1,500	\$600	\$600	\$1,000	\$600	\$600	\$1,000
– Payer 2							\$600	\$0	\$900	\$600	\$0	\$900
– Payer 3				\$1,500	\$600		\$1,200	\$600				
– Payer 4	\$0	\$1,500	\$3,000	\$0	\$0	\$1,500						
– Payer 5										\$600	\$300	\$900
– Payer 6	\$400	\$750	\$1,000							\$400	\$500	\$300
– Payer 7										None/\$0/100	\$0	\$300
– Payer 8	\$1,500	\$4,500	\$3,000	\$600	\$300	\$1,500						
– Payer 9				\$400	\$600	\$900	\$450			\$0		

* This information reflects Payer 8 plans only; it does not include information from subsidiaries.

	Individual Products			Small Group Products			Large Group Products					
							Insured			Self-Insured		
	First Most Common	Second Most Common	Third Most Common	First Most Common	Second Most Common	Third Most Common	First Most Common	Second Most Common	Third Most Common	First Most Common	Second Most Common	Third Most Common
Coinsurance levels												
– Payer 1				90%/70%	100%/70%	80%/70%	90%/70%	100%/80%	80%/60%	90%/70%	100%/80%	80%/60%
– Payer 2							90%	100%	80%	90%	100%	80%
– Payer 3				\$80%	60%		80%	60%				
– Payer 4	0%	80%	80%	100%	100%	75%	100%	100%	100%	100%	100%	100%
– Payer 5										90%	80%	100%
– Payer 6	80%	90%	100%							90%	80%	100%
– Payer 7										90%/80%	90%	80%
– Payer 8	80%/50%			100/70%	100/90/60%	100/100/70 %	100/70%	90/60%	80/50%	100/70%	90/60%	80/50%
– Payer 9				80%	90%	100%	80%			80%	90%	100%
Copays												
▪ Office visit												
– Payer 1				\$5	\$10	\$15	\$10	\$10	\$10	\$10	\$10	\$10
– Payer 2							\$10	\$15	\$20	\$10	\$15	\$20
– Payer 3				\$20	\$15	\$10	\$5	\$10	\$20			
– Payer 4	\$7	\$0	\$0	\$10	\$5	\$0	\$10	\$5	\$15	\$0	\$5	\$10
– Payer 5										\$15	\$10	\$25
– Payer 6	\$15	\$10	\$20							\$15	\$20	\$10
– Payer 7										\$10	\$0	\$0
– Payer 8	\$15			\$15	\$20	\$10	\$15	\$10	\$20	\$15	\$10	\$20
– Payer 9				\$10	\$15	\$20				\$10	\$15	\$20
▪ Hospital admission												
– Payer 1				\$0	\$100	\$200	\$250	\$250	\$500	\$250	\$250	\$500
– Payer 2							\$100		\$200	\$100		\$200
– Payer 4	\$0	\$0	\$0	\$100/3 day	\$100/3 day	Subject to ded.	\$100/3 adm	\$100/1 day	\$100/3 day	\$0	\$0	\$0
– Payer 5										\$250	\$100	\$200
– Payer 6	\$200									\$100		
– Payer 7										\$0	\$0	\$0
– Payer 8							\$75			\$75		
– Payer 9				\$0	\$100	\$250				\$0	\$100	\$200

	Individual Products			Small Group Products			Large Group Products					
	First Most Common	Second Most Common	Third Most Common	First Most Common	Second Most Common	Third Most Common	Insured			Self-Insured		
							First Most Common	Second Most Common	Third Most Common	First Most Common	Second Most Common	Third Most Common
▪ Other non-drug (Please specify.)												
– Payer 2 Emergency Room							\$50	\$50	\$75	\$50	\$50	\$75
– Payer 3 Emergency Room				\$100	\$75		\$50	\$75	\$100			
– Payer 4 Emergency Room	\$50	\$50	\$50	\$75	\$75	\$75	\$50	\$75	\$0	\$25	\$50	\$50
– Payer 9 (not specified)				varies widely	varies widely	varies widely				varies widely	varies widely	varies widely

	Individual Products			Small Group Products			Large Group Products					
	First Most Common	Second Most Common	Third Most Common	First Most Common	Second Most Common	Third Most Common	Insured			Self-Insured		
							First Most Common	Second Most Common	Third Most Common	First Most Common	Second Most Common	Third Most Common
Internal plan limits on days, visits, procedures, dollars or other												
▪ Mental health care												
– Payer 1				30 days IP/ 30 visits OP	30 days IP/ 30 visits OP	30 days IP/ 30 visits OP	30 days IP/ 20 visits OP	30 days IP/ 20 visits OP	30 days IP/ 20 visits OP	30 days IP/ 20 visits OP	30 days IP/ 20 visits OP	30 days IP/ 20 visits OP
– Payer 2							30 days	30 days	30 days	30 days	30 days	30 days
– Payer 4	Not covered	Not covered	10 visits @ \$30 copay & 12 days @ 80%	20 visits @ \$20	20 visits @ \$30	20 visits @ \$30	12 days @ 80%	30 days @ 100%	45 days @ 100%	12 days @ 80%	12 days @ 80%	12 days @ 80%
– Payer 5										50 visits	20 visits	30 visits
– Payer 6	\$10,500									\$10,000	\$10,500	\$20,000
– Payer 7										45 day/per year-90day lifetime IP	45 day/per year-90day lifetime IP	45 day/per year-90day lifetime IP
– Payer 8	Not covered			In Network IP – 12 days/yr OP – 15 visits/yr Extended Network IP – 6 days/yr OP – 12 visits/yr	IP – 8 days/yr OP – 12 visits/yr		12 most days			12 days		
– Payer 9				50 visits / 20 days	40 visits / 15 days					50 visits / 20 days	40 visits / 15 days	

* IP = inpatient; OP = outpatient

	Individual Products			Small Group Products			Large Group Products					
	First Most Common	Second Most Common	Third Most Common	First Most Common	Second Most Common	Third Most Common	Insured			Self-Insured		
							First Most Common	Second Most Common	Third Most Common	First Most Common	Second Most Common	Third Most Common
▪ Chemical depend. care												
– Payer 1				30 days/ visits IP and OP; \$10,000 lifetime maximum	30 days/ visits IP and OP; \$10,000 lifetime maximum	30 days/ visits IP and OP; \$10,000 lifetime maximum						
– Payer 2							State mandate	State mandate	State mandate	60 days	60 days	60 days
– Payer 4	Detox only @ 80%	Detox only @ 80%	Detox – 80% OP ded./ co-ins	\$10,680	\$10,680	\$10,680	\$10,680	\$10,680	\$10,680	\$10,680	\$10,680	\$10,680
– Payer 5										\$10,000	\$5,000	\$2,500
– Payer 6	\$10,500									\$10,000	\$10,500	\$20,000
– Payer 7										\$10,000 per episode/ma x lifetime \$20,000	\$10,000 per episode/ma x lifetime \$20,000	\$10,000 per episode/ma x lifetime \$20,000
– Payer 8	Not covered			\$10,500 every 2 calendar yrs.			\$11,000 every 2 yrs.			\$11,000 every 2 yrs.		
– Payer 9				\$2,000	\$2,500	\$3,000				\$2,500	\$2,000	\$5,000
▪ Home health care												
– Payer 1				120 visits	120 visits	120 visits						
– Payer 2							40 days	40 days	40 days	40 days	40 days	40 days
– Payer 4	In full	In full	Subject to deductible co-ins	In full	In full	In full	In full					
– Payer 5										130 visits	120 visits	100 visits
– Payer 7										130 visits	130 visits	130 visits
– Payer 8	130 visits/yr			130 visits/yr varies widely	varies widely	varies widely	130 visits			130 visits varies widely	varies widely	varies widely
– Payer 9												

	Individual Products			Small Group Products			Large Group Products					
	First Most Common	Second Most Common	Third Most Common	First Most Common	Second Most Common	Third Most Common	Insured			Self-Insured		
							First Most Common	Second Most Common	Third Most Common	First Most Common	Second Most Common	Third Most Common
▪ Skilled nursing facility care												
– Payer 1				90 days	90 days	90 days						
– Payer 2							60 days	60 days	60 days	60 days	60 days	60 days
– Payer 4	In lieu of IP	In lieu of IP	In lieu of IP	Not covered except in lieu of hospitalization	Not covered except in lieu of hospitalization	Not covered except in lieu of hospitalization	Not covered except in lieu of hospitalization	30 days	60 days			
– Payer 5										90 days	45 days	60 days
– Payer 7										\$100 per day 180 days max	\$100 per day 180 days max	\$100 per day 180 days max
– Payer 8	30 days/yr			90 days/yr			90 days/yr			90 days/yr		
– Payer 9				varies widely	varies widely	varies widely				varies widely	varies widely	varies widely
▪ Rehabilitation services												
– Payer 1				90 days	90 days	90 days	60 visits per occurrence	60 visits per occurrence	60 visits per occurrence	60 visits per occurrence	60 visits per occurrence	60 visits per occurrence
– Payer 2							60 days	60 days	60 days	60 days	60 days	60 days
– Payer 4	60 days	60 days subject to deductible/co-ins	60 days subject to deductible/co-ins	60 days	60 days	60 days	60 days	60 days	60 days	60 days	60 days	60 days
– Payer 5										\$3,000	\$5,000	\$2,000
– Payer 8	OP – \$1,500 yr			IP – \$30,000 condition OP – \$1,500 yr			\$30,000/condition			\$30,000/condition		
– Payer 9				varies widely	varies widely	varies widely				varies widely	varies widely	varies widely

	Individual Products			Small Group Products			Large Group Products					
	First Most Common	Second Most Common	Third Most Common	First Most Common	Second Most Common	Third Most Common	Insured			Self-Insured		
							First Most Common	Second Most Common	Third Most Common	First Most Common	Second Most Common	Third Most Common
▪ Other non-drug (Please specify.)												
– Payer 7 Hospice										\$10,000 lifetime	\$10,000 lifetime	\$10,000 lifetime
– Payer 7 Spinal										24 treatments per year	24 treatments per year	24 treatments per year
– Payer 9				varies widely	varies widely	varies widely				varies widely	varies widely	varies widely
Plan maximums (per lifetime)												
– Payer 1				Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
– Payer 2							\$1,000,000	Unlimited	\$2,000,000	\$1,000,000	Unlimited	\$2,000,000
– Payer 3				\$1,000,000	Unlimited		\$1,500,000	\$2,000,000				
– Payer 4	\$1,000,000	\$1,000,000	\$0	\$1,000,000	\$1,000,000	\$1,000,000	Unlimited	\$1,000,000	\$0	Unlimited	Unlimited	Unlimited
– Payer 5										\$1,000,000	\$2,000,000	\$3,000,000
– Payer 6	\$1,000,000									\$2,000,000	\$1,000,000	
– Payer 7										\$2,000,000	\$2,000,000	\$2,000,000
– Payer 8	\$1,000,000			\$2,000,000								
– Payer 9				\$1,000,000						\$1,000,000		
Annual out-of-pocket limits												
▪ Per individual												
– Payer 1				\$1,000	\$2,000	\$2,500	\$2,000	\$2,000	\$3,000	\$2,000	\$2,000	\$3,000
– Payer 2							\$1,000		\$2,000	\$1,000		\$2,000
– Payer 3				\$3,000	\$3,000		None	\$3,000				
– Payer 4	\$1,500	\$1,500	\$3,000	\$1,000	\$2,000	\$2,500	\$2,000	\$1,000	\$750	\$750	\$750	\$750
– Payer 5										\$2,000	\$1,000	\$5,000
– Payer 6	\$1,000	\$5,000								\$1,000	\$2,000	\$5,000
– Payer 7										\$500	\$0	\$1,000
– Payer 8	\$2,000	\$3,000	\$2,000	\$2,500 in network \$10,000 extended network	\$2,500	\$1,250	\$2,500			\$2,500		
– Payer 9				\$1,500	\$2,000	\$5,000				\$1,000	\$2,000	\$1,500

	Individual Products			Small Group Products			Large Group Products					
	First Most Common	Second Most Common	Third Most Common	First Most Common	Second Most Common	Third Most Common	Insured			Self-Insured		
							First Most Common	Second Most Common	Third Most Common	First Most Common	Second Most Common	Third Most Common
▪ Per family												
– Payer 1				\$3,000	\$6,000	\$5,000	\$4,000	\$4,000	\$6,000	\$4,000	\$4,000	\$6,000
– Payer 2							\$2,000		\$6,000	\$2,000		\$6,000
– Payer 3				\$5,000	\$6,000		None	\$6,000				
– Payer 4	\$3,000	\$3,000	\$6,000	\$3,000	\$6,000	\$7,500	\$4,000	\$2,000	\$1,500	\$1,500	\$1,500	\$1,500
– Payer 5										\$6,000	\$3,000	\$15,000
– Payer 6	\$2,500	\$7,500	\$10,000							\$2,500	\$5,000	\$10,000
– Payer 7										\$1,000	\$500	\$1,500
– Payer 8	\$6,000	\$9,000	\$6,000	\$7,500 in network \$30,000 extended network	\$7,500	\$3,750	\$7,500			\$7,500		
– Payer 9				\$3,000	\$4,000	\$15,000				\$2,000	\$0	\$6,000

6. What are your most frequent prescription drug cost-sharing approaches in private plans?

Private Plans	Individual Products		Small Group Products		Large Group Products			
	In-Network	Out-of-Network	In-Network	Out-of-Network	Insured		Self-Insured	
					In-Network	Out-of-Network	In-Network	Out-of-Network
Five most common cost-sharing arrangements (indicate brand vs. generic; formulary vs. non-formulary)								
▪ First								
– Payer 1			2 tier, closed formulary		2 tier, open formulary		2 tier, open formulary	
– Payer 2					10/20/40	40% coins	10/20/40	40% coins
– Payer 3			10-20-40 managed formulary		10-20-40 managed formulary			
– Payer 4	Copay		Copay	Co-insurance	Copay	N/A (HMO)	Copay	N/A (HMO)
– Payer 5							Brand	Generic
– Payer 6	80%						\$10/20/40	80%
– Payer 7							G- \$3/ B-\$10	0
– Payer 8	50%	Non-Par not covered	\$15 closed formulary	Non-Par not covered				
– Payer 9			Brand v. generic	co-insurance			Brand v. generic	co-insurance
▪ Second								
– Payer 1			3 tier, open formulary		\$5/\$10/\$25		\$5/\$10/\$25	
– Payer 2					7/15/35	20% coins	7/15/35	20% coins
– Payer 3			5-10 closed formulary		5-10 closed formulary			
– Payer 4	Not covered		Not covered	Not covered	Copay	Co-insurance	Copay	Co-insurance
– Payer 5							Formulary	Non-Formulary
– Payer 6	\$20/40/60	60%					\$20/40/60	60%
– Payer 7							G-100%/B-90%	0
– Payer 8			\$20 closed formulary	Non-Par not covered				
– Payer 9			Formulary	co-pay			Formulary	co-pay

Private Plans	Individual Products		Small Group Products		Large Group Products			
					Insured		Self-Insured	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
▪ Third								
– Payer 1			2 tier, open formulary		\$10/\$20/\$35		\$10/\$20/\$35	
– Payer 2					5/15/35	30% coins	5/15/35	30% coins
– Payer 3			10-20 closed formulary		10-20 closed formulary			
– Payer 4					Brand/generic	N/A (HMO)	Copay	N/A (HMO)
– Payer 5							Performance	Non-Performance
– Payer 6							\$5/10/25	80%
– Payer 7							G-90%/B-75%	0
– Payer 8			\$7 generic/ 30% brand 50% non-formulary	Non-Par not covered				
– Payer 9			Mail order				Mail order	
▪ Fourth								
– Payer 1			3 tier, \$5 generic/ \$10 brand formulary \$25 brand non-formulary		3 tier, generic and brand formulary have set copays, brand non-formulary is at a percentage of cost		3 tier, generic and brand formulary have set copays, brand non-formulary is at a percentage of cost	
– Payer 2					10/20	No coverage	10/20	No coverage
– Payer 3			5-10-25 managed formulary		5-10-25 managed formulary			
– Payer 4					Brand/generic	Co-insurance		
– Payer 7							G-100%/B-90%	G-90%/B-80%
– Payer 8			\$12 generic/ 30% brand 50% non-formulary	Non-Par not covered				
– Payer 9			Custom network				Custom network	

Private Plans	Individual Products		Small Group Products		Large Group Products			
					Insured		Self-Insured	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
▪ Fifth								
– Payer 1			3 tier, \$10 generic/ \$20 brand formulary \$35 brand non- formulary		Straight percentage of cost		Straight percentage of cost	
– Payer 2					7/15/40	No coverage	7/15/40	No coverage
– Payer 3			7.50-15 closed formulary		7.50-15 closed formulary			
– Payer 4					Not covered			
– Payer 7							G-90%/B-75%	0

7. What are your most frequent in- and out-of-network benefit differentials in private plans?

Private Plans	Individual Products		Small Group Products		Large Group Products			
					Insured		Self-Insured	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
▪ Five most common coinsurance arrangements (e.g., 90%/70%)								
– Payer 8	Selections providers	Participating providers	Selections or PPO providers depending upon plan type	Participating providers				

Private Plans	Individual Products		Small Group Products		Large Group Products			
					Insured		Self-Insured	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
– First								
♦ Payer 1			90%	70%	90%	70%	90%	70%
♦ Payer 2					90%	70%	90%	70%
♦ Payer 3 – A					90%	60%		
♦ Payer 3 – B					80%	50%		
♦ Payer 4	80%		100%	80%	100%		100%	
♦ Payer 5							90%	70%
♦ Payer 6	80%	60%					90%	70%
♦ Payer 7							90%	80%
♦ Payer 8	80%	50%	100%	70%	100%	70%	100%	70%
♦ Payer 9			90%	80%			100%	80%
– Second								
♦ Payer 1			100%	70%	100%	80%	100%	80%
♦ Payer 2					80%	60%	80%	60%
♦ Payer 4	0%		100%		100%	80%	100%	80%
♦ Payer 5							100%	80%
♦ Payer 6	90%	70%					80%	60%
♦ Payer 7							90%	90%
♦ Payer 8			100%/90%	60%	90%	60%	90%	60%
♦ Payer 9			100%	80%			90%	80%
– Third								
♦ Payer 1			80%	70%	80%	60%	80%	60%
♦ Payer 2					100%	80%	100%	80%
♦ Payer 4			75%	60%	100%	70%	100%	
♦ Payer 5							80%	60%
♦ Payer 6	90%	60%					100%	60%
♦ Payer 7							80%	80%
♦ Payer 8			100%	70%	80%	50%	80%	50%
♦ Payer 9			80%	70%			90%	70%

Private Plans	Individual Products		Small Group Products		Large Group Products			
					Insured		Self-Insured	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
– Fourth								
♦ Payer 1			80%	60%				
♦ Payer 2					90%	60%	90%	60%
♦ Payer 4			80%	70%	100%	75%		
♦ Payer 5							90%	80%
♦ Payer 7							100	85
♦ Payer 8			90%	60%				
– Fifth								
♦ Payer 1			90%	60%				
♦ Payer 2					100%	0%	100%	0%
♦ Payer 4			100%	75%	100%	60%		
♦ Payer 5							80%	50%
♦ Payer 7							80%	80%
♦ Payer 8			80%	50%				
▪ Five most common copay arrangements (e.g., \$10/\$25)								
– First								
♦ Payer 1			\$10		\$10		\$10	
♦ Payer 2					\$10		\$10	
♦ Payer 4	\$0 (HMO only)		\$10	Ded/co-ins	\$10		\$0	
♦ Payer 5							\$15	\$25
♦ Payer 6	\$20						\$20	
♦ Payer 7							\$10	80%
♦ Payer 8	\$15	\$15	\$15	\$15	\$15	\$15	\$15	\$15
♦ Payer 9			\$10				\$10	

Private Plans	Individual Products		Small Group Products		Large Group Products			
					Insured		Self-Insured	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
– Second								
♦ Payer 1			\$5		\$15		\$15	
♦ Payer 2					\$15		\$15	
♦ Payer 4	\$7 (HMO only)		\$10	HMO	\$5		\$5	Ded/co-ins
♦ Payer 5							\$10	\$15
♦ Payer 6	\$15						\$15	
♦ Payer 8			\$20	\$20	\$10	\$10	\$10	\$10
♦ Payer 9			\$25				\$15	
– Third								
♦ Payer 1			\$15		\$5		\$5	
♦ Payer 2					\$20		\$20	
♦ Payer 4	\$0 (HMO only)		\$5	Ded/co-ins	\$10	Ded/co-ins	\$10	
♦ Payer 5							\$20	\$25
♦ Payer 6	\$10						\$10	
♦ Payer 8			\$10	\$10	\$20	\$20	\$20	\$20
♦ Payer 9			\$15				\$20	
– Fourth								
♦ Payer 1								
♦ Payer 2					\$5		\$5	
♦ Payer 4	\$0 (HMO only)		\$5	HMO	\$5	Ded/co-ins		
♦ Payer 5							\$10	\$25
♦ Payer 6							\$25	
– Fifth								
♦ Payer 1			\$25					
♦ Payer 2					\$25		\$25	
♦ Payer 4	\$0 (HMO only)		\$15	Ded/co-ins	\$15			
♦ Payer 5							\$10	\$20

8. Please outline your primary gatekeeper (utilization management) requirements, and the types of benefits affected. *(Please check all applicable items.)*

- Payer 4 is a coordinated healthcare plan. As such, our providers (staff and contracted) determines through protocol and judgement when, what, where and how a patients needs are best met.

Private Plans	Individual Products*	Small Group Products	Large Group Products	
			Insured	Self-Insured e.g., voluntary case management
Hospitalization				
▪ Payer 1		X	X	X
▪ Payer 2			Mandatory Pre-admittance Certification	Mandatory Pre-admittance Certification
▪ Payer 5				Mandatory Preauthorization – 5 day prior
▪ Payer 6	X			X
▪ Payer 7				Some pre-certification required on high cost procedures.
▪ Payer 9		IP preauthorization	IP preauthorization	IP preauthorization
Selected diagnosis				
▪ Payer 1		X	X	X
▪ Payer 2			X	X
▪ Payer 5				N/A
▪ Payer 6	X			X
Selected treatment				
▪ Payer 1		X	X	X
▪ Payer 2			X	X
▪ Payer 5				N/A
▪ Payer 6	X			X

Private Plans	Individual Products*	Small Group Products	Large Group Products	
			Insured	Self-Insured e.g., <i>voluntary case management</i>
Non-formulary				
▪ Payer 1		X	X	X
▪ Payer 2			Optional	Optional
▪ Payer 5				N/A
▪ Payer 7				Most plans utilize a Voluntary Formulary, one has a restricted formulary with a 50% reimbursement of non-formulary medications.

- *e.g., mandatory pre-admission certification*

9. With regard to your private group plans, please provide your minimum underwriting rules for insured groups.

Private Plans	Small Group (Insured)	Large Group (Insured)
Minimum number of hours employees must work to qualify for coverage		
▪ Payer 1	30 hours per week	25 hours per week
▪ Payer 2		30 hours per week
▪ Payer 3	20 hours per week	20 hours per week
▪ Payer 4	17.5 hours per week	17.5 hours per week
▪ Payer 7		40-80 hours per week/month
▪ Payer 8	20 hours per week	20 hours per week
Minimum employer contribution toward employee coverage		
▪ Payer 1	50% – 75%	50% – 75%
▪ Payer 2		50% overall for employees and dependents
▪ Payer 3	75%	50%
▪ Payer 4	75%	75%
▪ Payer 7		100%
▪ Payer 8	50%	75%

Private Plans	Small Group (Insured)	Large Group (Insured)
Minimum employer contribution toward dependent coverage		
▪ Payer 1	50%	50%
▪ Payer 2		50% overall for employees and dependents
▪ Payer 3	0%	0%
▪ Payer 4	0%	0%
▪ Payer 7		100%
▪ Payer 8	0%	0%

10. What, if any are the major distinguishing features of private plans you offer in different parts of Washington?

Private Plans	Individual	Small Group	Large Group	
			Insured	Self-Insured
Northwest Washington				
▪ Payer 1		Web-Enabled Member Services <ul style="list-style-type: none"> ▪ Personal web site ▪ Medical/dental health information ▪ ID Card, EOB, claim status, E-mail member service functions ▪ PCP change, selection, physician lookup/ browse functions Special Programs <ul style="list-style-type: none"> ▪ Vision discounts ▪ Health club discounts ▪ Alternative care provider discounts 	<ul style="list-style-type: none"> ▪ Insured and provider report card capabilities ▪ Local, experienced account service team ▪ Significant health and welfare penetration in the 3,000+ Northwest marketplace 	<ul style="list-style-type: none"> ▪ Large, cost-effective PPO/POS/EPO network ▪ Local service center ▪ Customer provider report card capabilities ▪ Local experience account service team ▪ Significant health and welfare penetration in the 3,000+ Northwest marketplace
▪ Payer 2			Payer 2 offers the same plan options statewide.	
▪ Payer 3		Small and large group plans are available in the service area: King, Pierce, Snohomish, Thurston, Lewis, Mason and Spokane counties.		
▪ Payer 9	N/A	Varies widely	Varies widely	Varies widely

Private Plans	Individual	Small Group	Large Group	
			Insured	Self-Insured
Seattle Area				
<ul style="list-style-type: none"> Payer 1 Payer 2 Payer 3 		Same as Northwest	Same as Northwest	Same as Northwest
			Payer 2 offers the same plan options statewide.	
		Small and large group plans are available in the service area: King, Pierce, Snohomish, Thurston, Lewis, Mason and Spokane counties.		
Southwest Washington				
<ul style="list-style-type: none"> Payer 1 Payer 2 		Same as Northwest	Same as Northwest	Same as Northwest
			Payer 2 offers the same plan options statewide.	
Northeast Washington				
<ul style="list-style-type: none"> Payer 1 Payer 2 		Same as Northwest	Smaller medical network but strong Northwest presence as noted above	Smaller medical network but strong Northwest presence as noted above
			Payer 2 offers the same plan options statewide.	
Spokane Area				
<ul style="list-style-type: none"> Payer 1 		Same as Northwest	Smaller medical network but strong Northwest presence as noted above	Smaller medical network but strong Northwest presence as noted above
<ul style="list-style-type: none"> Payer 2 Payer 3 			Payer 2 offers the same plan options statewide.	
		Small and large group plans are available in the service area: King, Pierce, Snohomish, Thurston, Lewis, Mason and Spokane counties.		
Southeast Washington				
<ul style="list-style-type: none"> Payer 1 Payer 2 		Same as Northwest	Smaller medical network but strong Northwest presence as noted above	Smaller medical network but strong Northwest presence as noted above
			Payer 2 offers the same plan options statewide.	

11. From your organization's perspective, what are the reasons certain features, and variations among them, become commonplace or unusual?
(1=most important reason, 2=second most important reason, etc.)

Reason	Payer 1	Payer 2	Payer 3	Payer 4	Payer 5	Payer 6	Payer 7	Payer 8	Payer 9
▪ Insurance mandates	3	1		2	2	1	2		
▪ Marketplace demands	1 (cost)	2		1	1	2	1		2
▪ Ease in administration	4	3		3	3	3	3		
▪ Ease in communicating	5	4		4	4	4	4		

Appendix G

Washington State Mandated Benefits*

Mandated Benefits Requiring Specific Services	
Chemical dependency	Phenylketonuria (PKU)
Dependent child coverage from moment of birth	Neurodevelopmental therapy
Prohibition of benefit reduction based on existing coverage (Coordination of Benefits)	Mammograms
Reconstructive breast surgery	Maternity care stays (drive through deliveries Erin Act)
Mastectomy and lumpectomy	Newborn coverage for 21 days (Erin Act)
Basic Health Plan Benefits: Physician services, inpatient and outpatient hospital services, prescription drugs and medications, and other services that may be necessary for basic health care. If funds are available, chemical dependency services, mental health services and organ transplant services	Diabetes coverage
Emergency services to screen and stabilize	Maternity and drugs in the individual market
Long-term care hospital follow-up	General anesthesia for dental procedures
Mandated Benefits Requiring Offerings	
Home health and hospice	Prenatal diagnosis of congenital defects
Mental health	Temporomandibular joint disorders (TMJ)
Chiropractic care	
Mandated Benefits Requiring Access to Providers	
Chiropody	Psychological services
Podiatry	Registered nurses and advanced registered nurse practitioners
Foot care services	Denturist services
Optometry	Every category of provider
Chiropractic care	Chiropractic care, non-referral access
Women's health care provider self-referral	
Mandated Benefits Establishing Eligibility	
Dependent child coverage continued for incapacity	Continuation of benefits
Dependent child coverage from moment of birth	Coverage for adopted children
Continuation of coverage for former spouse and dependents	Guaranteed issue to new members of a group, and continuity of group contract coverage
Group conversion plan to be offered	Portability

* Excerpted from, "Washington State Mandated Benefits" (Office of Insurance Commissioner, January 10, 2002)

* A silent PPO allows plan participants and sponsors to obtain the financial advantages of PPO discounts simply by "accidentally" using network providers, without having plan design incentives to use them.